

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

September 16, 2026

[REDACTED] ADMINISTRATOR
THE ROBERT PACKER HOSPITAL
[REDACTED]

RE: THE ROBERT PACKER HOSPITAL
PERSONAL CARE HOME
603 WILLIAM STREER
TOWANDA, PA, 18848
LICENSE/COC#: 22987

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/25/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE ROBERT PACKER HOSPITAL PERSONAL CARE HOME**License #:** 22987**License Expiration:** 07/08/2027**Address:** 603 WILLIAM STREER, TOWANDA, PA 18848**County:** BRADFORD**Region:** NORTHEAST

Administrator

Name: [REDACTED]**Phone:** [REDACTED]**Email:** [REDACTED]

Legal Entity

Name: THE ROBERT PACKER HOSPITAL**Address:** [REDACTED]**Phone:** [REDACTED]**Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-1**Date:** 01/07/2021**Issued By:** L&I

Staffing Hours

Resident Support Staff: 0**Total Daily Staff:** 85**Waking Staff:** 64

Inspection Information

Type: Full**Notice:** Unannounced**BHA Docket #:****Reason:** Renewal**Exit Conference Date:** 06/25/2026

Inspection Dates and Department Representative

06/25/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 94**Residents Served:** 84

Secured Dementia Care Unit

In Home: No**Area:****Capacity:****Residents Served:**

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0**Are 60 Years of Age or Older:** 83**Diagnosed with Mental Illness:** 1**Diagnosed with Intellectual Disability:** 1**Have Mobility Need:** 1**Have Physical Disability:** 1

Inspections / Reviews

06/25/2026 Full

Lead Inspector: [REDACTED]**Follow-Up Type:** POC Submission**Follow-Up Date:** 07/27/2026

08/06/2026 - POC Submission

Submitted By: [REDACTED]**Date Submitted:** 09/10/2026**Reviewer:** [REDACTED]**Follow-Up Type:** POC Submission**Follow-Up Date:** 08/13/2026

Inspections / Reviews (*continued*)

09/09/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/10/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/11/2026

09/16/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/10/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED] Resident #1 fell and hit their head on the door. The resident was sent to the hospital for a visible right eye injury. The resident returned after receiving several stitches. The home did not report this incident to the department until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 09/09/2026)

The Administrator, [REDACTED], has been educated on the requirement to report all incidents within 24 hours (calendar days). The Administrator will assume responsibility for all reportable incidents being submitted. The Administrator will submit all reportable injuries within 24 hours as per regulation. All reportable incidents will be audited monthly by the Administrator to ensure 100% compliance for 3 months. If less than 100% compliant, audits will continue an additional 3 months until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented ([REDACTED] - 09/16/2026)

101j2 - Bedroom Chairs

2. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom 310 is occupied by 2 residents; however, there is only 1 chair in this room.

Plan of Correction

Accept ([REDACTED] - 09/09/2026)

The Administrator, [REDACTED], has had all rooms audited to ensure there is 1 chair per person in each room. All rooms without a chair have been replaced with a chair on 7/23/26.
The Administrator will assume responsibility to ensure chair audits will be completed monthly x 3 months. Following the 7/26/26 audit, monthly audits will be continued in August 2026. If less than 90% compliance, will continue for additional 3 months until 90% compliance is achieved.

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented ([REDACTED] - 09/16/2026)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #2 and resident #3 do not have access to a source of light that can be turned on/off at bedside.

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction

Accept () - 09/09/2026

The Administrator, (), had all rooms audited on 7/23/26 to ensure there is a working source of light that can be turned on/off at the bedside. All rooms without this have been replaced with a working light source on 7/23/26.

The Administrator will assume responsibility to ensure light audits are completed monthly x 3 months continuing in August 2026. If less than 90% compliance, will continue for additional 3 months until 90% compliance is achieved.

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 09/16/2026

102i - Soap Dispenser

4. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled used bar of soap in room 310. This room is shared by 2 residents.

Repeated violation 3/25/25 et al.

Plan of Correction

Accept () - 09/09/2026

The Administrator, (), had all rooms audited to ensure there is a soap dispenser for each resident or a labeled soap dish for each resident. Any resident without will be replaced by August 30, 2026.

The Administrator will assume responsibility of ensuring soap dispenser/soap dish audits will be completed monthly x 3 months. Following the August audit, audits will continue monthly in September 2026. If less than 90% compliance, will continue for additional 3 months until 90% compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented () - 09/16/2026

103f - Refrigerator/Freezer Temps

5. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the freezer in the first-floor dining room.

Plan of Correction

Accept () - 09/09/2026

The Administrator, (), replaced the thermometer in the freezer on 6/26/26. The Administrator will assume responsibility to ensure thermometer audits are completed monthly x 3 months continuing in July 2026. If less than 90% compliance, will continue for additional 3 months until 90% compliance is achieved.

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 09/16/2026

121a - Unobstructed Egress

6. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 9:31 a.m. in the 2nd floor dining room there was a pallet stored on the floor in front of the door blocking egress to the emergency exit.

At 9:44 a.m. on the 2nd floor west wing, the exit door that leads to the kitchen was obstructed by a cart and blocked egress to the emergency exit.

Plan of Correction

Accept () - 09/09/2026

The Administrator, (), has ensured the pallet and cart that was stored/blocking egress to the emergency exit has been removed on 7/21/26. The Administrator will assume responsibility that audits will be conducted on emergency exits on 1st, 2nd, and 3rd floor monthly x 3 months. Following the 7/21/26 audit, audits will continue in August 2026. If less than 90% compliance, will continue for additional 3 months until 90% compliance is achieved.

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 09/16/2026

132c - Fire Drill Records

7. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 9/11/25 at 4:00 p.m. does not include the correct time the fire drill was conducted. As confirmed through interviews with staff, the fire drill was conducted at 4:00 a.m.

Plan of Correction

Accept () - 09/09/2026

The documentation on the fire drill was conducted 9/11/25 at 4:00 am on the fire drill record. However, on the fire drill log record 2600.132, the fire drill documented the fire drill was conducted at 4:00 pm. The Administrator, (), has corrected the form 2600.132 as appropriate to 4:00 am on 7/23/26. The Administrator, (), will ensure responsibility of updating the fire drill log record 2600.132 at all times.

Licensee's Proposed Overall Completion Date: 08/31/2026

Implemented () - 09/16/2026

184a - Resident's Meds Labeled

8. Requirements

2600.

184a - Resident's Meds Labeled (continued)

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #5 has an order for Metoprolol Succinate 50 mg extended release tablets to be administered twice daily at 9:00 a.m. and 8:00 p.m. The order states the medication is to be held if the residents systolic blood pressure is less than 110. The medication label does not include the blood pressure parameter.

Resident #6 has an order for one Ipratropium-Albuterol vial to be nebulized twice daily at 9:00 a.m. and 8:00 p.m. The medication label states to inhale 3ml every 4 hours as needed.

Resident #7's order for PRN Tylenol 325mg states take 2 tabs by mouth every 6 hours as needed. The medication label states, Acetaminophen 325mg take 2 tablets by mouth four times a day as needed for pain.

Plan of Correction

Accept () - 09/09/2026)

Resident #5, #6, #7 medication labels/MARS have been corrected so medication matches the order on 7/24/26 by the LPN at the Personal Care Home. The Administrator will assume responsibility that all medication carts and MARS will be audited monthly with 10 random audits/cart to ensure medication labels match medication order. Audits will be conducted monthly x3 months continuing August 2026. If less than 100% compliance, additional 3 months audits will be conducted until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented () - 09/16/2026)

185a - Implement Storage Procedures**9. Requirements**

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer: Resident # 4-At 4:00 p.m. on 6/22/26, the glucometer reading was 249 and the Medical Administration Record, MAR, was incorrectly transcribed as 243, and at 8:00p.m. on 6/24/26, the glucometer reading was 64 and the Medical Administration Record, MAR, was incorrectly transcribed as 66.

Plan of Correction

Accept () - 09/09/2026)

The Administrator, [REDACTED], will ensure all glucometers are audited monthly to ensure glucometer readings match the transcribed MAR documentation. The Administrator will ensure all audits are completed monthly x3 months to ensure 100% compliance. Audits started August 2026 auditing the month prior. If less than 100% compliance, additional 3 months audits will be conducted until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 11/01/2026

185a - Implement Storage Procedures (*continued*)*Implemented () - 09/16/2026)*

187a - Medication Record

10. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

4. Strength.

8. Frequency of administration.

11. Special precautions, if applicable.

Description of Violation

Resident #5 has an order for Metoprolol Succinate 50 mg extended release tablets to be administered twice daily at 9:00 a.m. and 8:00 p.m. The medication is to be held if the residents systolic blood pressure is less than 110. The resident's medication administration record does not include the blood pressure parameter.

Resident #6 has a PRN order for Albuterol HFA 90mcg Inhaler to inhale 2 puffs as needed for shortness of breath. The resident's medication record indicates to to take 1 or 2 puffs as needed.

Resident #7's order for PRN Nitroglycerin states 0.4 mg. The resident's medication administration record states 0.3 mg.

Plan of Correction*Accept () - 09/09/2026)*

Resident #5, #6, #7 medication labels/MARS have been corrected so the medication matches the order on 7/24/26 by the LPN at the Personal Care Home.

The Administrator has assumed responsibility to ensure that all medication carts and MARS will be audited monthly with 10 random audits/cart to ensure medication labels match medication order. Audits will be conducted monthly x3 months. Audits will begin August 2026. If less than 100% compliance, additional 3 months audits will be conducted until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented () - 09/16/2026)

224a - Preadmission Screen Form

11. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's pre-admission screening dated () did not indicate that the needs of the resident can be met in the Personal Care Home.

Plan of Correction*Accept () - 09/09/2026)*

The Administrator, (), reviewed Resident #3's prescreen and corrected the unmarked check box to verify resident meets the criteria to live at the Personal Care Home on July 21, 2026. The Administrator will assume responsibility to ensure pre-screen audits will be conducted on all residents monthly resuming in August 2026 x 3

224a - Preadmission Screen Form (continued)

months to ensure pre-screen are completed entirely. If less than 100%, additional 3 months of audits will be completed until 100% compliance

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 09/16/2026)

225a - Assessment 15 Days**12. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3's initial assessment dated [REDACTED] did not include the resident's use of a walker.

Repeated violation 3/25/25 et al.

Plan of Correction

Accept () - 09/09/2026)

The Administrator, [REDACTED], on 7/21/26 updated Resident #3's assessment to include that of a walker. The Administrator will assume responsibility to ensure audits are completed on all RASP's continuing in August 2026 to ensure completion. Audits will be conducted monthly x3 months. If less than 100% compliance, additional 3 months audits will be conducted until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 11/01/2026

Implemented () - 09/16/2026)

225c - Additional Assessment**13. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident #8's annual assessment dated [REDACTED] does not indicate the services or frequency Hospice and Private Duty Aide provide.

Plan of Correction

Accept () - 09/09/2026)

The Administrator, [REDACTED], has updated Resident #8's annual assessment on 7/21/26 to include hospice services and private duty aide services. The Administrator will assume responsibility to ensure audits are completed on all RASP's. Audits will be conducted monthly x3 months continuing August 2026. If less than 100% compliance, additional 3 months audits will be conducted until 100% compliance is obtained.

Licensee's Proposed Overall Completion Date: 10/01/2026

Implemented () - 09/16/2026)